TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy and Discount, LLC

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-17-1093-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier, Zurich failed to take final action within the 45-day period set forth in TAC §134.240. Specifically the claim was submitted on 9/19/16 and it was received by the provider on 9/26/16 … and no action was taken on the claim. Sentrix made a good faith effort to notify the carrier of their failure to respond to the bill on 11/14/16 and it was received by the provider on 11/22/16 … Again, no action was taken on the claim."

Amount in Dispute: $1,244.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier never received the billings. It appears that the provider sent billings to some incorrect address in Fort Worth. Carrier does not have any bill review in Fort Worth."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2016	Pharmaceutical Services, Compound	$1,244.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. The submitted documentation did not include explanations of benefits.

Issues

1. What are the services in dispute?
2. Did Sentrix Pharmacy and Discount, LLC (Sentrix) submit a bill for the service in question in accordance with 28 Texas Administrative Code §133.20?

Findings

1. Sentrix is seeking reimbursement of $1,244.50 for a compound dispensed on September 19, 2016, consisting of the following ingredients:

    - Salt Stable LS Base, NDC 00395602157, 85.20 gm
    - Baclofen 4%, NDC 38779038808, 4.80 gm
    - Amantadine 8%, NDC 38779041109, 9.60 gm
    - Amitriptyline 2%, NDC 58597800308, 2.40 gm
    - Gabapentin 5%, NDC 58597801407, 6.00 gm
    - Ketoprofen 10%, NDC 58597801707, 12.00 gm

    This is the service considered in this dispute.

2. Flahive, Ogden & Latson stated in its position statement on behalf of Zurich American Insurance Company that "The carrier never received the billings. It appears that the provider sent billings to some incorrect address in Fort Worth. Carrier does not have any bill review in Fort Worth." 28 Texas Administrative Code §133.20(a) states, "The health care provider shall submit all medical bills **to the insurance carrier** except when billing the employer in accordance with subsection (j) of this section." Review of the submitted documentation does not support that Sentrix sent the bills for the service in question to the insurance carrier or to the employer, in accordance with 28 Texas Administrative Code §133.20. For this reason, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.